

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-61-039811

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

STATE FILE NUMBER

AMENDED

Registration District No. 333 Primary Registration District No. 3074 Registrar's No. 198

1. PLACE OF DEATH a. COUNTY <b>Scott</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MO</b> b. COUNTY <b>Scott</b>				
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <b>Sikeston</b>		Length of stay in 1b		c. CITY OR TOWN <b>SIKESTON</b>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <b>Mo. Delta Comm. Hospital</b>			Inside Limits Yes <input type="checkbox"/> No <input type="checkbox"/>		d. STREET ADDRESS (If outside, give location) <b>216 N. WEST ST</b>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>ANDERSON</b> Middle <b>H</b> Last <b>HOBBS</b>			4. DATE OF DEATH Month <b>10</b> Day <b>7</b> Year <b>1961</b>					
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <b>6-6-1877</b>	9. AGE (last birthday) <b>84</b>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HR Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>		11. BIRTHPLACE (City and state or country) <b>HARDIN Co ILL</b>		12. CITIZEN OF WHAT COUNTRY <b>USA</b>		
13a. FATHER'S NAME <b>ISAAC HOBBS</b>			13b. MOTHER'S MAIDEN NAME <b>unknown</b>		14. NAME OF HUSBAND OR WIFE <b>SARAH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Mrs Ethel Bond, Matthews Mo R2</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>BRONCHOPNEUMONIA</b> DUE TO (b) <b>Gen. a.s. ART. NEPHROSIS.</b> DUE TO (c) <b>ART. SCLER. HEART DIS.</b> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) <b>CER. ART. SCLEROSIS WITH CHR. BRAIN SYNDR.</b>						PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)						
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year			20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>9-21-61</b>		20f. CITY, TOWN, OR LOCATION <b>Sikeston, Mo.</b>		COUNTY		STATE		
21. I attended the deceased from <b>5:45 P.</b> to <b>10-7-1961</b> and last saw him alive on <b>10-7-1961</b> Death occurred at <b>5:45 P.</b> m on the date stated above, and to the best of my knowledge, from the causes stated.								
22a. SIGNATURE <b>Carl G. [Signature]</b> (Degree or title)				22b. ADDRESS <b>Sikeston, Mo.</b>		22c. DATE SIGNED <b>10-8-61</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>10-9-61</b>	23c. NAME OF CEMETERY OR CREMATORY <b>City</b>		23d. LOCATION (City, town, or county) (State) <b>SIKESTON MO</b>				
24. FUNERAL DIRECTOR <b>Welch Funeral Home - Sikeston Mo</b> ADDRESS			25. DATE RECD. BY LOCAL REG. <b>10-10-61</b>		26. REGISTRAR'S SIGNATURE <b>Mrs Ora O. Hall a Reg</b>			

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

DOCUMENT

MEDICAL CERTIFICATION

SHOULD READ

BY AFFIDAVIT OF

ITEM NO.

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed Raymond Lewis

Licensed Embalmer No. 3467

P. O. Address Sikeston Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).  
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.  
If this body is not embalmed, fact should be so stated above.